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TALKS

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Psychiatry, anti-psychiatry, and anti-anti-psychiatry: Rhetoric and reality

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Abstract

The term "anti-psychiatry" was coined in 1912 by Dr. Bernhard Beyer, and popularized by David Cooper and his critics in 1967 in the midst of a widespread cultural revolt against involuntary hospitalization and in-patient psychiatry. However, with the demise of the old-fashioned mental hospital, and the rise of Big Pharma (with all its attendant evils), the term "anti-psychiatry" has survived as a term of abuse or a badge of honor, depending on the user and what rhetorical work the term is expected to perform. Those who still use the term generally have a polemical axe to grind, and seldom understand either the term's origins or its contemporary implications. It is time to retire this term, or to restrict its use (as much as possible) to R. D. Laing's followers in the Philadelphia Associates and kindred groups that sprang up in the late 1960s and 1970s.

KEYWORDS

anti-psychiatry, Big Pharma, DSM-5, normalization, psychiatry, psychoanalysis, psychopolitics

1 | INTRODUCTION

In the spring of 2000, shortly after the publication of the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV; American Psychiatric Association, 2000), I gave a guest lecture to a group of psychiatric residents at the Western Psychiatric Institute and Clinic (WPIC) in Pittsburgh, Pennsylvania. WPIC is among the largest and most prestigious psychiatric hospitals in the world, and has multiple affiliations with the University of Pittsburgh, where I was a visiting fellow at the Center for the Philosophy of Science at the time. My presentation that day was called "What is Wrong With the DSM?" Among other things, I noted that the steady proliferation of new categories of mental disorder in each successive edition of the DSM prompted skepticism and the suspicion that psychiatrists were revising and expanding their criteria of mental disorder to include shyness, grief, mourning, adolescent mood swings, and other behavior that, up until recently, had been considered normal, or at any rate, not indicative of psychopathology. I said that the DSM was bloated, and that a consistent application of Ockham's razor—or the principle of parsimony, as some prefer to call it—would help us to whittle it down to size. I also pointed out that there were serious conflicts of interest among the panels of experts who were tasked with revising or formulating new categories of mental disorder, because

many of them received research money, handsome honoraria, and free vacations from drug companies in return for endorsements of their products, adding that the fear or perception of collusion or impropriety was extremely damaging to the DSM's credibility in the longer term.

Among those present at my talk was Dr. David Kupfer, who would be appointed Chair of the DSM-5 task force in 2007. He appeared to listen attentively, but the only time he actually spoke (on this occasion) was when I raised the issue of conflicts of interest. I don't remember his exact words, but he said that the public's fears concerning conflicts of interest were warranted, and that psychiatry would have to "clean house" in preparation for the next round of revisions, which would soon get under way.

Welcome as it was, this brief acknowledgement from Dr. Kupfer did not deter several of the psychiatric residents from angrily accusing me of being a charlatan; someone who knew nothing about medicine or science, who was no better than a Scientologist like Tom Cruise, and so forth. Neither Dr. Kupfer nor any of the other senior psychiatrists who were present that day said anything to deter or apologize for these abusive remarks from WPIC residents, which elicited audible murmurs of approval among the 60 (or so) psychiatrists and psychiatrists-in-training who were assembled in the room. I left WPIC under a cloud, never to return.

One year later, in June of 2001, the Canadian Broadcasting Corporation reported on the case of David Healy, a world-renowned psychiatrist who wrote a three-volume history of psychopharmacology and taught at the University of Bangor in Wales. The University of Toronto had recently hired him as their Chief of Psychiatry with much public fanfare, and then abruptly dismissed him. Why? Because during his inaugural lecture, he spoke candidly about the potential dangers of Prozac, which causes one in 1,000 patients to become suicidal (or, more rarely, homicidal). Apparently, the pharmaceutical companies that sponsor drug research at the University were horrified, and threatened the Department of Psychiatry that if they kept Healy as chair of the department they would withdraw all their funding. Not surprisingly, Psychiatry capitulated and eventually settled with Healy out of court.

Now, in case you've forgotten, Prozac was approved by the FDA in 1988, faster than any other drug in that agency's history. It was also the subject of a best-selling book, *Listening to Prozac* (Kramer, 1993), which made the drug—and other SSRIs—wildly popular. Ten years later, and only two years after the University of Toronto debacle, Professor Healy released a book entitled *Let Them Eat Prozac* (2003). He cautioned Canadians (and the world at large) that pharmaceutical companies routinely suppress evidence from experimental trials that contradicts their claims for the efficacy of their drugs and downplay evidence of their potential side-effects.

That was 2003; fast-forward five years to 2008. Planning for the DSM-5 (American Psychiatric Association, 2013) was underway in earnest, and Senator Charles ("Chuck") Grassley, the ranking Republican on the Senate Finance Committee chaired an inquiry that revealed massive collusion between Big Pharma and the psychiatric profession. Grassley's investigation targeted Dr. Joseph Biederman, the head of Pediatric Psychopharmacology at Harvard, Dr. Allan Schatzberg, Head of Stanford's Psychiatry Department and President elect of the American Psychiatric Association, and Dr. Charles Nemeroff, the Chair of Psychiatry at Emory University. All three men were principal investigators for major research projects on the effectiveness of new pharmacological agents. Put differently, Biederman, Schatzberg, and Nemeroff (and their associates) had reached the top of the psychiatric food chain, where they received millions of dollars in corporate sponsorship for their "research," along with stock dividends in the companies that sponsored their research, and whose products they, in turn, endorsed. They also received gratuities of various kinds, including free vacations, lavish meals, and so on. Nemeroff was guilty of not disclosing personal gifts from pharmaceutical companies to the tune of $500,000 (Angell, 2009). Biederman did not declare most of the $1.6 million in income and gifts that he received from Big Pharma. But of these three psychiatrists, the case of Alan Schatzberg was the most disturbing. Please recall that Schatzberg was the President-elect of the American Psychiatric Association. Grassley discovered that Schatzberg controlled more than $6 million worth of stock in Corcept Therapeutics, a company that he had cofounded. At the same time, he was the principal investigator on a National Institutes of Mental Health (NIMH) grant that included research into a drug that Corcept Therapeutics was testing as a treatment for psychotic depression, and had co-authored three papers on the subject. In the interests of averting a major scandal, Schatzberg stepped aside and handed the Presidency of the American Psychiatric Association over to someone else.

But Stanford University, Schatzberg's employer, still leapt to his defense, and professed to see nothing wrong with this state of affairs (Angell, 2009).

Now, I am not a psychiatrist. But I am a psychologist, and when I ponder Stanford's response to Grassley's investigation, I simply can't tell whether Schatzberg and his associates were engaging in conscious hypocrisy, or whether they really believed their own flimsy rationalizations for his ethical misconduct. And even if I could make that determination satisfactorily, I still for the life of me could not decide which scenario is more bizarre and disturbing. Were Schatzberg and associates genuinely incapable of discerning his malfeasance, or were they trying to pull one over on the rest of us? Either way, the story of Schatzberg and Co. illustrated the extent to which conflict of interest and plain old corruption had become the new normal, infiltrating the highest levels of the psychiatric profession. As Marcia Angell pointed out in *The New York Review of Books* the following year, about two thirds of academic medical centers hold equity interest in companies that sponsor research within the same institution. And a recent study of medical school chairs found that two thirds received departmental income from drug companies and three fifths received personal income of some kind (Angell, 2009).

If I did not know better already, I would venture to guess that no rational person would trust *any* of the research conducted in such cozy and corrupt circumstances. But the facts suggest otherwise. In 2005, one in 10 American citizens had a prescription for anti-depressant medication, and by 2010 a hundred and sixty-four million prescriptions were written for anti-depressants and sales totaled 9.6 billion dollars (Menand, 2010). And that is just anti-depressants! Sales for anxiolytics, anti-psychotics, and "mood stabilizers" were also mounting steadily at that time. Nowadays, one in five American adults is taking psychiatric medications—all of which, without exception, are neurotoxins, and injurious to brain health if taken over extended periods of time.

Not content with this degree of market penetration, psychiatry and Big Pharma started medicating children extensively during the second Bush administration; now many children under the age of two are receiving multiple medications that were never even tested on children in the first place (Burston, 2010). Worse yet, everyone acknowledges that none of these drugs actually *cures* anything. They merely alleviate or mask the symptoms of the underlying disorder, often at the cost of considerable side effects. Yes, some patients swear by these drugs and claim they have saved their lives. Others, however, are demonstrably worse when they take them and desperately seek less toxic alternatives.

Marcia Angell's revelations about the collusive relationships and conflicts of interest in psychiatry and Big Pharma appeared in 2009, and from then until 2013, when the DSM-5 finally appeared, there was a steady drumbeat of criticism about the entire process by means of which the latest (American) taxonomy of mental disorder was being put together. And to the astonishment of many, some of the strongest criticism came from Dr. Robert Spitzer and Dr. Allan Frances, who had chaired the DSM-III and DSM-IV task forces respectively. They criticized David Kupfer and his team for being overly secretive and unscientific in their approach. Though Spitzer's critique of the new DSM was quite forceful, Frances's critique was especially intriguing to me because it echoed my own misgivings about the DSM-IV thirteen years previously, some of which I had outlined in the final chapter of a book entitled *The Crucible of Experience: R. D. Laing and the Crisis of Psychotherapy* (Burston, 2000). Though he never acknowledged the extent to which the problems with DSM-5 were foreshadowed in DSM-IV, which was his brain child, Frances did perform a service by detailing his objections to the DSM-5 in a book entitled *Saving Normal: An Insider's Revolt Against Out of Control Diagnosis, DSM-5, Big Pharma and the Medicalization of Ordinary Life* (Frances, 2013).

Now, do these historical reflections, that are culled from my personal recollections, mark me as an "anti-psychiatrist"? I suppose that depends on whom you talk to. Though I am extremely critical of the psychiatric profession, and published two books on R. D. Laing, who is often (mistakenly) credited with starting the anti-psychiatry movement, I have never advocated abolishing psychiatry entirely. Nevertheless, many psychiatrists have insisted on calling me an "anti-psychiatrist" over the years. Why? Probably because I am not a psychiatrist myself, and therefore lack standing in their eyes. But, by the same token, the psychiatrists who've dismissed me as an ill-informed yokel would not dare call Robert Spitzer or Allan Frances "anti-psychiatrists," because they had a big hand in shaping the previous

psychiatric consensus about what is (and is not) indicative of a mental disorder. In short, it almost appears that to criticize psychiatrists, you have to be a member of their club first to be considered credible—at least in their eyes. At the very least, you need to have MD after your name. But even that won't buy you complete immunity. The late Thomas Szasz was a psychiatrist who claimed that there is no such thing as mental illness—that the term "mental illness" is merely a metaphor for disturbed and disturbing states of mind that lack any clear-cut organic etiology. And he is often called an anti-psychiatrist, though he has vigorously rejected the label.

Pondering these ironies in 2013, it dawned on me that the term "anti-psychiatry" has probably outlived its usefulness. Why? Because in most instances when this term is invoked or applied—whether to oneself or one's adversaries—it is riddled with ambiguity, or the kind of brazen mystification and double-think born of covert partisanship masquerading as science. Granted, those who do advocate the total abolition of the psychiatric profession may cling to this label, if they wish. But, by and large, the term "anti-psychiatry" is used as a term of derogation by psychiatrists to lump many cogent and thoughtful critics of psychiatry together indiscriminately, and to silence, ignore, or drastically oversimplify their individual contributions in the process. Alternatively, many of those who do want to abolish psychiatry embrace this term as a badge of honor, but are extremely ill-informed about its actual history and meaning. Just go online and read the feverish exchanges between psychiatrists, anti-psychiatrists, and self-styled "anti-anti-psychiatrists." (No, I am *not* making this up!)

To put these developments into context, however, it is not enough to rehash the history of psychiatry in the twenty-first century. In the interests of clarity, we must go back much further, to the 1960s, and then work our way up to the present. But before we launch into the next round of historical reflection, please ask yourself the following questions: Who is (or is not) an "anti-psychiatrist," and how (and why) should the "anti-psychiatry" label be applied to specific theorists, especially if these critics of psychiatry actually reject this label? And why do laymen and scholars alike persist in attributing an "anti-psychiatric" attitude—which they may embrace or deplore—to those who vigorously disclaim it? In the end, I will argue, it is mostly a matter of perspective, and what semantic work the term "anti-psychiatry" is expected to perform in the context of a specific writer's narrative—in other words, whom it is that the writer really wishes to attack, defend, or offend through the application of this label.

So, for the record then, please note that the term "anti-psychiatry" was coined by a German doctor named Bernhard Beyer in 1912, to describe an article—and more broadly, a sensibility—that was severely critical of psychiatry at that time (Szasz, 1976b). While popular protests against involuntary psychiatric hospitalization did, in fact, occur in the late nineteenth and early twentieth century (Dain, 1989; Shorter, 1995), the term "anti-psychiatry" was seldom used prior to 1967, when David Cooper, a South African psychiatrist, popularized the term in a book entitled *Psychiatry and Anti-Psychiatry* (1967). According to Cooper, "anti-psychiatry" was an approach to the remediation of psychotic symptoms developed jointly by him and other members of the Philadelphia Association. The Philadelphia Association was a London charity founded in 1964 to create therapeutic households where deeply disoriented and distressed people could avoid the indignities of psychiatric diagnosis and coercive treatment, and gradually recover their emotional equilibrium.

Though Cooper popularized the term "anti-psychiatry," it is often associated with his more famous colleague, R. D. Laing, who rose to international fame on the sales of his book *The Politics of Experience and the Bird of Paradise* (Laing, 1967). Laing was convinced that mainstream Kraepelinian psychiatry contained many unquestioned assumptions and biases, including the belief that the discourse of patients diagnosed with schizophrenia is "unintelligible," meaningless, irrelevant to context, or the product of brain dysfunction (Burston, 1996). The critique of (in-patient) psychiatry that Laing and his associates articulated in the early 1960s was sharply critical of mainstream psychiatric theory and practice, and drew on diverse bodies of thought, including existentialism, phenomenology, psychoanalysis (Burston, 1996), the sociology of deviance (Goffman, 1961; Scheff, 1976) and communications studies (Bateson, Jackson, Haley, & Weakland, 1956).

Nevertheless, it is important to note that, unlike Thomas Szasz, with whom he is often linked, Laing never said that there is no such thing as madness or mental disorder. On the contrary, he acknowledged that madness and misery are closely conjoined, and that delusions and hallucinations reflect a deeply disturbed (and disturbing) state of mind. But,

by his reckoning, madness is *not meaningless*, nor is it merely an anomaly that afflicts people with severe neuropathology. Indeed, said Laing, we are all potentially mad, madness being the default position of people who are paralyzed by social situations or familial systems that they do not understand, cannot tolerate, and are simply powerless to change, regardless of their neurological integrity or lack of it (Burston, 1996; Laing & Cooper, 1964; Laing & Esterson, 1964).

Sadly, said Laing, mainstream psychiatry's bias toward biological reductionism prompts most practitioners to ignore patients' social contexts, robbing their symptoms of their "social intelligibility." As a result, psychiatrists tend to invalidate, rather than address, the patient's (often inarticulate) attempts to address their peculiar and tormenting situations, with the result that no meaningful or authentic communication takes place between the psychiatrist and patient, and no genuine therapeutic rapport can be established (Laing, 1961; Laing & Cooper, 1964; Laing & Esterson, 1964). Meanwhile, whether they are aware of it or not, the families of deeply disturbed patients often have a vested interest in silencing "the identified patient," because her delusions and hallucinations evoke disturbing hints of traumas, family secrets, or interpersonal states of affairs that are disjunctive with the family's idealized self-image—what family therapists used to call "the family myth" (Laing, 1971).

That being so, said Laing, mental health workers are often faced with a stark choice—either assist their patients in unraveling the complex interpersonal stratagems or "knots" that bind them in misery and confusion, or keep things "under control" through coercive treatments (for example, drugs or electroshock treatment). If they opt for the latter course, said Laing, mental health workers cease to be real healers, because mainstream treatments may normalize patients' experience and behavior somewhat, but only at the cost of preventing them from experiencing and expressing themselves authentically, without addressing the underlying interpersonal issues, and—ironically enough—at considerable cost to their neurological integrity.

Laing produced his best work between 1960 and 1968. Then in 1971, while Laing was in India and Ceylon studying yoga and meditation, David Cooper published another book, entitled *The Death of the Family*. Unlike Laing, who had drifted away from left-wing politics since 1967, Cooper embraced a radical political agenda, which linked the antipsychiatry movement, as he defined it, with the Third World's struggle against imperialism and a wholesale condemnation of the nuclear family. On returning from his Asian interlude, Laing was deeply dismayed by the tone of Cooper's second book. From that point onwards, he repudiated the antipsychiatry label. But the fact that Laing rejected that label, then and for the remainder of his life, did not prevent others from applying it to him and, increasingly, to a growing number of theorists who had little or no personal connection to him.

By contrast with Laing, whom others have variously described as a left-leaning Scottish nationalist or as a Romantic liberal, Thomas Szasz, by his own admission, was a right-wing radical (Szasz, 1976a). He detested Laing and Cooper's anti-capitalist and anti-imperialist rhetoric (Szasz, 1976b), and rejected "anti-psychiatry" with at least as much vehemence as he rejected much of psychiatry itself. If you don't believe me, just consider the title of his very last book—*Antipsychiatry: Quackery Squared* (Szasz, 2012). Szasz abhorred anti-psychiatry, and might aptly be described as an "anti-anti-psychiatrist." But as Seth Farber recently observed, in the last few decades, ex-psychiatric patients or "psychiatric survivors" who ardently embrace the "anti-psychiatry" label base their calls for the abolition of the psychiatric profession on Szaszian premises, and know little or nothing of Laing, who has been all but forgotten (Farber, 2012).

Along with Thomas Szasz, who had a libertarian axe to grind, R. D. Laing's most vehement critic in the United States was E. Fuller Torrey (Torrey, 1983). Torrey adhered closely to the neo-Kraepelinian approach to research and treatment and condemned any effort to address or "demystify" the patient's family situation through family therapy, which he construed as a form of misdirection that put too much blame on parents. As a result of his influence, family therapy for schizophrenia today consists almost entirely in "educating" families as to the "real" (neurobiological) causes of the disorder and providing them with strategies to cope more effectively with emotional stress and the (inevitable) side effects (for the patient) of taking psychiatric drugs for the remainder of one's life.

Meanwhile, a handful of British psychiatrists, including Anthony Clare, Anthony Storr, and F. A. Jenner thought Laing's critique of prevailing psychiatric theory and practice had some merit, and sought to engage Laing in dialogue (Clare, 1976; Jenner, 2001; Storr, 1978). These men were psychiatric humanists who believed in listening attentively

to their patients, and in trying to get beyond overt symptomatology to the lived human reality behind them. Though they were respected members of the psychiatric establishment, they became outliers where Laing was concerned. As the 1980s wore on, psychiatry divested itself of any lingering vestiges of psychoanalytic theory and practice, and the vast majority of psychiatrists tuned these men out. They regarded Laing as dangerous, delusional, or both. So, Torrey won and the others lost, at least in the court of psychiatric opinion.

Why did Torrey's scathing dismissal of R. D. Laing win out over Storr, Jenner, and Clare's more generous appraisals? One reason, no doubt, was that Laing was a scathing critic of normalcy. Like Erich Fromm, Herbert Marcuse, and other well-known intellectuals of that era, Laing believed that the social system we inhabit is extremely alienated and alienating. Bland, "conflict-free" adjustment to prevailing circumstances is not to be confused with genuine mental health, which requires more realism, authenticity, and courage than is expected of the average or "normal" person. According to Laing, prevailing modes of socialization leave "well-adjusted" people immersed in "social phantasy systems," or consensually validated "pseudo-realities," rather than in touch with existential actualities (Laing, 1961). Normality impairs their critical faculties, and their ability to empathize with people who are not members of their immediate reference groups. So, by Laing's account, normality is more akin to a deficiency disease than it is to genuine mental health (Burston, 1996). In light of the preceding, Laing said, therapists should never promote adjustment or adaptation for its own sake, which all too often is precisely what psychiatry tries to do (Laing, 1967).

Another forceful critic who opposed psychiatry's program of "normalization" was French philosopher Michel Foucault, whose book *Madness and Civilization* appeared in English in 1971. Foucault was as critical of psychiatry as Laing, and often for similar reasons, Unlike Laing, however, who leaned on psychoanalytic theorists like Paul Federn, Frieda Fromm-Reichmann and Harry Stack Sullivan (among others), Foucault was utterly dismissive of psychoanalysis, shunned comparisons with British and American thinkers, and, by the time *Madness and Civilization* appeared, had publicly abandoned or repudiated existentialism, phenomenology, and Marxism, embracing a new post-structuralist epistemology that, as far as he was concerned, completely nullified or superseded these earlier schools of thought, with which Laing and his followers were still very much involved.

So, Laing, Szasz, and Foucault, who are widely regarded as the leading theorists of the anti-psychiatry movement, all rejected the anti-psychiatry label, and disagreed emphatically with one another on a wide range of issues. Perhaps the first person to appreciate the intriguing oddity of this situation was Peter Sedgwick, a Marxist sociologist in the UK. Sedgwick's book *Psychopolitics* (1982), a landmark study, made the point that for all their similarities, the substantive differences between Laing, Szasz, and Foucault really outweigh their similarities—not just in their own minds, but in ways that have profound consequences for social policy and the political economy of mental health care. For example, Szasz railed against involuntary hospitalization, but had no objection whatsoever to voluntary (outpatient) psychiatry, provided that the patient paid the doctor for his services directly out of pocket, without government or insurance schemes acting as middle men. As a right-wing libertarian, Szasz greeted any form of state sponsorship or support for treatment in the mental health arena—even those that are relatively benign or positively helpful—as a waste of taxpayers' money and/or a thinly disguised attempt at social control.

Meanwhile Foucault, who was on the Left, went even further than Szasz, and treated even private (out-patient) psychotherapy and psychoanalysis as another (covert) form of social control. Unlike Foucault, Szasz and Laing—for different reasons, and in different ways—continued to believe in the emancipatory potential of individual psychotherapy; in its power to liberate us from our fears, fixations, and harmful patterns of interpersonal relatedness. And, unlike Laing and associates, who tried to create viable alternatives to conventional mental hospitals and sought financial support for their efforts, Foucault was not imagining, much less offering, alternatives to the status quo. He completely refused to engage in projects of that sort, pursuing a relentless critique of all power relations, in the hope and expectation that such critique would (at some point) show us the way to a better future.

In view of the prevailing tendency to lump all of psychiatry's best-known critics into a single category, despite their emphatic objections, *Psychopolitics* offered readers a refreshing change of perspective (Sedgwick, 1982). Sadly, only a minority of scholars have followed in Sedgwick's footsteps and kept the differences between Szasz, Laing, and Foucault firmly in mind (for example, Parker, Georgaca, Harper, McGlaughlin, & Stowell-Smith, 1995). For most

psychiatrists and psychiatric historians, the differences between them—and between all of them and Scientology, by the way—are utterly inconsequential. And so, while some psychiatrists have pronounced anti-psychiatry "dead" (for example, Nasser, 1995; Tantum, 1991), most psychiatrists and their apologists continue to use the term "anti-psychiatry" in a hostile, indiscriminate fashion to demonize or dismiss anyone they believe has mischaracterized or unjustly attacked their profession.

A recent case in point; on January 10, 2017, Barbara Kay published an article in a Canadian newspaper, *The National Post*, entitled "U of T's 'antipsychiatry' scholarship—and not believing in mental illness—is an attack on science." In it, she attacked Barbara Burstow, an Associate Professor of Adult Education and Community Development at the Ontario Institute for Studies in Education, for creating a scholarship to write PhD dissertations on anti-psychiatry. Barbara Kay was only four sentences into her article when she invoked the Tom Cruise analogy, effectively conflating the complex and carefully wrought arguments of formidable thinkers like Laing, Szasz, and Foucault (among others) with a discredited cult that masquerades as a religion. And a few sentences later, she claimed that many of the injustices that Burstow blames on psychiatry are really the fault of psychoanalysis, which once dominated psychiatry, but has no basis in medicine and which psychiatry jettisoned decades ago.

In fairness to Barbara Kay, psychoanalysis has much to answer for. But careful scrutiny of the historical record demonstrates the nullity of this claim. Indeed, to lay the blame for all of psychiatry's sins on the doorstep of Freud and his followers is either deeply disingenuous or willfully blinkered; the kind of absurdly selective and specious reasoning one expects to find deployed in all-out ideological warfare, not in sober and searching historical analysis. Rather than dwelling further on the contents of the article, such as it is, I'd like to draw your attention to an historical irony that is unwittingly embedded in the very title of Barbara Kay's complaint; one which illustrates the intense confusion and mystification that infuses these increasingly sterile and pointless debates. The man who claimed that mental illness is a myth—namely, Thomas Szasz (1974)—was also the author of a book entitled *Antipsychiatry: Quackery Squared* (2012). In short, and by his own admission, Szasz was an anti-anti-psychiatrist, just like his staunch opponent, Barbara Kay—or wasn't he? (Talk about strange bedfellows!)

So, though it is still far from clear just who is (or is not) an anti-psychiatrist, or indeed an anti-anti-psychiatrist, both critics and defenders of mainstream psychiatric theory and practice continue to use this term as if its meaning were self-evident. Articles like Barbara Kay's—of which there are far too many, nowadays—demonstrate that this is simply not the case. Conversely, those who use "anti-psychiatry" as a term of dismissal—mostly psychiatrists, psychiatric historians, and journalists who need a convenient "hook" to hang their stories on—lump many cogent critics of psychiatry who are calling for radical reform together with those who advocate its outright abolition; among them, the followers of that well-known charlatan, L. Ron Hubbard. As a result, at one point or another, the label has been applied to the work of psychiatrists Peter Breggin (USA) and David Healy (UK), psychologists Richard Bentall (UK) and Ian Parker (UK), journalists Robert Whitaker (USA) and Marcia Angell (USA), and documentarian Kevin Miller (USA). And yet with rare exceptions (for example, Parker et al., 1995), today's anti-psychiatrists don't resemble R. D. Laing and his followers very much. After all, they are not versed in phenomenology, existentialism, or psychoanalysis—or if they are, they certainly don't advertise that fact. Nor, with rare exceptions, do they dwell on the problems and perils of in-patient psychiatry, or call the concepts of normality and adaptation into question, or probe deeply into disordered communication among family members of psychiatric patients. On the contrary, they studiously avoid these issues—which are often simply *non-issues* in the contemporary arena. And rather than dispute or deny the merit of the medical model, or seek alternative models and methods to replace it, they usually stress the widespread and thoroughly mind-boggling *debasement* of the medical model brought about by the psychiatric profession's (increasingly transparent) collusion with the multinational machinations of Big Pharma.

One thing is certain: if there still is an anti-psychiatric "movement" today, it bears little resemblance to its former self, and has willfully repressed or simply abandoned many of its previous ideas and commitments. So, despite all the sound and fury, when all is said and done the question of who is (or is not) an anti-psychiatrist remains moot. I would invite scholars, rather than flogging a dead horse, to follow in Sedgwick's (1982) footsteps, and to differentiate clearly between Laing's leftish, eclectic counter-cultural cohort and their relentless right wing nemesis, Thomas Szasz;

between Laing, Szasz, and Foucault; and between these three theorists and all the critics who came afterwards (Breggin, Healy, Bentall, Parker, Whitaker et al.) who focus primarily on out-patient psychiatry and a widening range of psychiatric diagnoses (rather than the psychoses). Careful, credible historical analysis like this would also enable us to discriminate clearly between thoughtful, reform-minded critics, who embrace terms like "democratic psychiatry," "critical psychiatry," and more recently "post-psychiatry" (Lewis, 2006) rather than "anti-psychiatry," and those who want to abolish psychiatry outright (including Scientologists).

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